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Social Policy in Venezuela

Bucking Neoliberalism or Unsustainable Clientelism

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Acronyms

AD	*Acción Democrática* (Democratic Action, Venezuelan Social Democrat political party)
COPEI	*Comité de Organización Política Electoral Independiente* (Christian Democrat Party)
CVSS	*Centro Venezolano de los Seguros Sociales* (Venezuelan Social Security Centre)
HEMA	Health and Environment Ministers of the Americas
ISI	Import Substitute Industrialization
IVSS	*Instituto Venezolano de los Seguros Sociales* (Venezuelan Institute of Social Security)
MSAS	*Ministerio de Sanidad y Asistencia Social* (Ministry of Health and Social Assistance)
MSDS	*Ministerio de Salud y Desarrollo Social* (Ministry of Health and Social Development)
OAS	Organization of American States
OPEC	Organization of Petroleum Exporting Countries
PB-2000	*Plan Bolívar-2000*
PDVSA	*Petróleos de Venezuela, S.A.* (Petroleum Venezuela, state owned national oil company)
PCV	*Partido Comunista de Venezuela* (Venezuelan Communist Party)
SAPs	Structural Adjustment Policies
VBEC	Venezuela Basic Economy Corporation

Abstract

This paper highlights the institutions, actors and processes that have driven social policy provision and health care in Venezuela during distinct political periods. The historical detail contextualises a protracted struggle over the distribution of the country's oil wealth. The paper concurs with the importance of democracy, political will and a favourable international context in driving public access to health care but emphasises that situations of institutional and political decomposition as inherited by President Hugo Chávez require researchers and policy makers to engage with non-traditional mechanisms for articulating and responding to health care needs, and the importance of avoiding the temptation of writing these off as crude 'populist' experiments. The case of Venezuela illustrates the significant challenge of peacefully addressing the political roots of social inequality and the obstacles that can be posed to improving access to health and social development by conservative opponents and vested interests, including in the trade union movement and nominally social democratic parties.

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Introduction

This paper examines the social protection policies, or *misiones* introduced in Venezuela by the government of President Hugo Chávez (1998–2013). Health care is a focus of the paper, which contextualizes and evaluates the government's attempts to implement an integrative model of coverage informed by participatory and social medicine approaches. It is argued that the achievements were significant, particularly given the social, political and economic crisis inherited by Chávez, but that health and other welfare initiatives are unsustainable without major institutional and macroeconomic policy change. With the death from cancer of Chávez in March 2013 and subsequent narrow victory of his successor Nicolás Maduro, political conditions are not conducive to reform processes that are necessary to consolidate the advances that have been made.

Venezuela has "special status" as one of the world's leading oil exporters. The first half of the paper details the relationship between this export commodity and welfare provision in the country, from origins as a rudimentary social assistance framework crafted during hesitant steps toward democracy in the 1930s to bankruptcy in the 1980s. Venezuela's experience is a complex story of petroleum-induced economic boom in the 1930s and 1970s and economic crisis in the 1980s. The most significant welfare gains were made by formal sector workers in the pre-boom period of the 1970s and then eroded as Venezuela entered cycles of economic expansion and contraction.

As in many Latin American countries, the application of Structural Adjustment Policies (SAPs) in the late 1980s negatively impacted on social provision. While the regressive effects of Venezuela's neoliberal experience are not underestimated, it is argued these were exacerbated by pre-existing structural problems that already threatened the viability of the welfare state model.[1] These included exclusion of informal and large numbers of agricultural sector workers; inequitable patterns of oil rent distribution; and the corruption, clientelism and institutional sclerosis that resulted from a model of "pacted" democracy that prevailed from 1958–1998. It was this context that framed popular support for Chávez in the presidential election of 1998, and the appeal of his revolutionary programme of participatory democracy and the use of the country's oil "wealth" for social development against a trend of oil sector privatization.

As a means of analysing the actors, institutions and processes driving social policy during the Chávez presidency, the second half of the paper explores the political and economic conditions that shaped the government's social policy approach and the ideological perspectives that framed strategy. Three phases of social policy evolution are identified, with the period following a coup attempt against Chávez in 2002 through to the presidential election of December 2006 identified as the most innovative.

It is acknowledged that Venezuela's social policy initiatives are deeply contested. There are questions as to the extent to which the Chávez government simply replicated problems of clientelism, corruption and oil rent dependence. While these critiques are acknowledged, it is argued that these inevitable limitations should not detract from the

[1] For example, in Venezuela's "*Barrio Adentro:* Participatory Democracy, South-South Cooperation and Health Care for All", Muntaner et al. (2008) argue that *Barrio Adentro* is an articulation of "popular resistance to neoliberalism".

value of drawing "lessons learned" from alternatives to marketized social protection schemes and innovative forms of health care that have been developed in Venezuela.

Contextualizing Social Provision in Latin America

The literature on social policy in Western societies points to the influence of industrialization and democratization on the type of welfare states that emerged.[2] Divergence in the process and timing of economic and political modernization generated distinct configurations of state and class power that influenced diversity in welfare state outcomes.

Huber and Stephens identify a "robust relationship" between democracy and social spending (2012:49) and the importance of the international context in structuring conditions favourable to state welfare initiatives. In particular, secularism and the presence of viable and autonomous left of centre forces were associated with peaceful distributive change. In Navarro and Shi's analysis (2001) the key determinant of the depth of welfare provision was not just the presence of an organized left, but their *capacity* to govern and *willingness* to enact social policy measures when in power.

The Latin American experience contrasts with that of Western Europe. Structural conditions conducive to the early emergence of strong welfare states were absent. The region experienced colonization and delayed and "dependent" development (Toye and Toye 2003). Insertion into the global economy was premised on the export of raw materials, with a resulting vulnerability to international price fluctuations and balance of payments deficits that regimes sought to overcome through strategies of import substitute industrialization pursued from the late 1930s. Democratization was hesitant following independence in the nineteenth century, with military strongmen or *caudillos* contesting power. There are examples of "enlightened authoritarianism" with health and education provision introduced during nation building projects of the late nineteenth century; but the structural drivers of universalized welfare state provision that existed in Europe were not present in the region. The colonial legacy, including the influence of the Roman Catholic Church and *encomienda* system of large landed colonial estates were not addressed (Frankema 2006). As a result, profound inequalities in land and capital asset distribution persisted, with social stratification cleaving around race, heritage and gender (Psacharopoulos and Patrinos 1994).

At the turn of the twentieth century, a new political economy of neo-colonialism emerged with the rise of the United States (US). Patterns of economic change during this period embedded the wealth and power division between a small Iberian Creole elite and the majority, comprising indigenous population and imported slaves from Africa.

The US originally claimed the southern hemisphere within its sphere of interest through the Monroe Doctrine of 1820. However, its interactions with Latin America were limited and centred on Mexico. This changed in the 1890s following economic contraction and corporate mergers in the US, and a quest for empire under President Theodore Roosevelt as the US embraced its "Manifest Destiny". As outlined by Grandin (2006), "many of America's largest international corporations got their start in Latin America, as capitalists poured billions into the region, first in mining, railroads and sugar, then in electricity, oil and agriculture". This was underpinned by a "growing sense of racial superiority" and commitment to the virtues of "individualism,

[2] Esping-Andersen 1999; Cereseto and Waitzkin 1986; Stephens 1979; Pampel and Williamson 1989.

competitiveness innovation, self-discipline, respect for private property, and as a reward for such commendable behaviour, consumerism" (Grandin 2006:19).

The US presence and alliance with local *caudillos* imposed limitations on land reform and democracy. Inequalities became embedded through the pattern of US economic extraction, while the capacity of nascent labour movements to lobby for social rights was repressed. With the advent of the Cold War and following the Cuban revolution of 1959, the rise of left wing parties and governments was curbed by brutal right wing military interventions and counter insurgencies that froze rather than addressed pressures for economic and political reform as in Guatemala (1954), Brazil (1964), Argentina (1966 and 1976), and Chile and Uruguay (1973). The variables influencing the emergence of robust welfare state models in Western Europe's social democracies were absent. The US economic and intellectual influence made for an international context antithetical to the instauration of state welfare regimes and Latin America was permeated by the *laissez faire* ideals of its Northern neighbour.

Import substitute industrialization and incipient welfarism

Existence within the US sphere of influence meant that Latin America experienced only infrequent bursts of democratization. This allowed for the election of progressive, multiclass or "mass" parties of the centre left. Examples include the *Partido Justicialista* (Peronists) in Argentina, the *Partido Revolucionario Institucional* in Mexico, the *Alianza Popular Revolucionaria Americana in Peru*, and, as discussed below, *Acción Democrática* (AD) in Venezuela. These periods are associated with the introduction of basic public welfare regimes (Haggard and Kaufman 2008) and the adoption of Import Substitute Industrialization (ISI) strategies and Keynesian economic policies. According to Muntaner et al. (2006) although inefficiently and inequitably stratified into parallel, hierarchical systems, social services that aimed at social equality, including in health care, expanded in most Latin American countries.

However, in contrast to working class and labour autonomy in the West European experience, the Latin American welfare regimes emerged from state-led initiatives to co-opt the labour and to a lesser extent, rural sectors. Access was contingent on party political and client-patron relations and did not represent a redistribution of political power. Welfare provision was an imposed social contract and not the result of bargaining outcomes. Class based demands were demobilized by the mass parties and subsumed into a broader "national" interest that was socially constructed as shared between workers, the emerging middle class and the elite. A key preoccupation was the defence of democracy from military intervention, and as a result, redistributive demands were played down and the tax catch remained chronically low. This institutionalized inequalities in the distribution of marketable assets and asymmetries in political power during periods of "democracy".

The advances that were made in universalizing access to public health, education and pension provision were set back as the ISI model indicated "exhaustion" during the international oil price and interest rate rises of the 1970s. Welfare spending was negatively impacted by the deteriorating capacity of the state to maintain its financial commitments. The military assumed power in most countries and through a new cycle of repression, Latin America was guided to an era of externally imposed, neoliberal economic strategies that dismantled "the post-war system of state regulation of the economy at a vertiginous pace" (Smith and Korzeniewicz 1997:1).

Venezuela followed the generic trajectory of Latin America, but with some differences linked to the country's status as an oil exporter. These were not significant enough to preclude the regional trend of debt, structural adjustment and political crisis, which in Venezuela's case, led to the election of Chávez.

Rents and welfare: The historical foundations of Venezuelan health care

A Ministry of Health and Social Assistance (*Ministerio de Sanidad y Asistencia Social*, MSAS) was first established in Venezuela in 1936 during the presidency of Eleazar López Contreras (1935–1941). This period marked steps to constitutionalism after military autocrat Juan Vicente Gómez (1908–1935), whose protracted rule had brought stability and centralization to Venezuela after a tumultuous century of *caudillo* conflict.

The Gómez dictatorship had coincided with the discovery and exploitation of the country's oil resources, which made Venezuela the world's second largest oil producer by 1928 (McBeth 2009). However, the income for Venezuela was modest. The 1910 Mining Code under which concessions were initially granted to private foreign oil companies only provided for general taxes to be paid to the state. This was a ground rent, with the state receiving revenues in return for permitting private sector territorial access to its hydrocarbon reserves. No financial value was placed on the oil produced and exported out of the country, with Venezuela gaining only a royalty that was established at between seven and 10 per cent in 1922. The state did not establish itself as a *proprietor* of the oil. It simply *administered* the relationship between the private sector and national hydrocarbon resources.[3] Royalties were invested in "nation building" projects such as transport and communications infrastructure that connected the national territory and newly industrializing towns in oil producing regions (Angarita 2009) but it was not until López Contreras that attention was paid to social need and health care in a rapidly changing country context.

The boom in exploration and production activities during the 1920s telescoped social and political change in a traditionally rural country dependent on coffee and cacao exports. According to Baptista (1997), Venezuela was a country in "absolute misery" as its oil economy expanded. Average annual income was $147, making Venezuela one of the poorest countries in Latin America. Average life expectancy was 34 years with preventable diseases including malaria, yellow fever, Chagas disease and cholera the principle causes of death. An estimated 75 per cent of the population was illiterate and half were informally employed on landed estates.

Although oil was a capital rather than a labour intensive industry and generated negligible domestic employment, its exploration and production transformed the economy. By 1935 the sector's contribution in taxes and royalties accounted for 91 per cent of total exports, from 28 per cent in 1925 (Tugwell 1975). The agricultural sector went into decline as blocks of land were sold for oil exploration and as urbanization was accelerated by employment opportunities in centres of oil production and state investment in capital projects (Toro Hardy 1992).

Three factors linked to the oil economy influenced steps to public health provision under López Contreras in the mid-1930s. The first was the physical presence of the foreign oil companies as the government issued over 4,000 exploration and production

[3] Coronil 1997; Hellinger 2000; Mommer 1983, 1986 and 2003.

concessions before the start of the Second World War. According to Tinker Salas (2009) Royal Dutch Shell, Creole (a subsidiary of Standard Oil) and Mene Grande (Gulf Oil) were an exemplar of social service provision in the expansive oil camps that sprang up in enclaves across Venezuela. The oil camps[4] provided a "new economic modernity" of housing, health and education provision. Although the quality of services was stratified along lines of corporate hierarchy, the benefits that were provided privileged petroleum sector workers over the 98 per cent of Venezuelans employed in the non-oil sector. Moreover: "the industry's residential complexes were a social laboratory where companies promoted labour practices, notions of citizenship and an accompanying world view" (Tinker Salas 2009:13). With nearly a quarter of Venezuelans living near oil camps, this model of corporate paternalism pressured a state response to the dualism between the modernity of the oil sector and the backwardness of Venezuelan society.

Tinker Salas (2009), Rivas (2002) and Grandin (2006) highlight the inter-related role of Standard Oil's Nelson Rockefeller and his development company, the Venezuela Basic Economy Corporation (VBEC) in the dissemination of public health concepts in Venezuela, while Kornblith and Maingon (1985) emphasize the importance of Rockefeller's philanthropy in launching anti-malaria campaigns in the country in the 1920s. Beyond disseminating public health care concepts, the VBEC's model of "missionary capitalism" pioneered investments in food and dairy production, supermarkets and financial and technical support to land improvement schemes, exemplifying to the state initiatives for national development. The VBEC lobbied for the use of taxes and royalties on oil to be used for national improvement, including through joint cooperation schemes between the Venezuelan state and VBEC. Philanthropy dampened an emerging nationalist backlash against the US oil corporations. But debates over the limited benefits accruing to the Venezuelan population as a result of the commodity "wealth" intensified in the 1930s. These were led by incipient political organizations such as the PCV and AD[5] parties (Betancourt 1978).

The second way in which hydrocarbon resources influenced moves toward welfare provision relate to the economic and class changes triggered by oil exploitation. Incipient political organizations of the 1920s and 1930s were rooted in the emerging middle and working classes of university students and industrial workers, as well as important peasant organizations. Proposals for more effective use of oil resources for national development and social justice were articulated by this new generation of activists and thinkers, such as Salvador de la Plaza on the communist left (Hellinger 2000), and social democrats Rómulo Betancourt and Juan Pablo Pérez Alfonzo, founders of the AD party in 1941. Particularly influential was Arturo Uslar Pietri and his notion of "Sowing the Oil" (*Sembrar el Petroleo*) that was first published in the magazine *Ahora* in July 1936. Appointed education minister by General López Contreras in 1938, Uslar Pietri popularized the concern that Venezuela's finite resources were exhaustible. His calls for better capture of the revenues from this one time gift from nature in order to achieve national development—a great leap forward—were influential in moving a reforming dictatorship toward state responsibility for public policy.

A third, oil related factor requiring the state to address public health was the impact of mass migration on the spread of infection and disease in unsanitary urban settlements.

[4] See Assignment Venezuela http://www.youtube.com/watch?v=AaVEKcpUQe8 (Accessed 13 November 2014).

[5] Communist Party of Venezuela (*Partido Comunista de Venezuela*, PCV) in 1931, Democratic Action (*Accion Democratica*, AD, 1941 from its forerunner *Partido Democracia Nacional*) and COPEI in 1946 evolving from the *Accion* Electoral party of the 1920s.

Tuberculosis, pneumonia and dysentery added to the litany of public health problems that influenced the creation of the MSAS, which assumed responsibility for disease prevention, health promotion and provision of a small number of state-funded and centrally administered hospitals. Alongside the MSAS, which received approximately five per cent of the national budget, a series of national institutes and specialized health, hygiene, cancer and therapy divisions were established between 1936 and 1945 to support preventive medicine, including in childhood, maternal and rural health care. These initiatives are attributed with halving infant mortality rates, increasing life expectancy to 57 years and reducing incidents of malaria to just triple figures by the mid-1940s. By way of contrast, there were an estimated six million cases of malaria per year during this decade in neighbouring Brazil (Oliveira-Ferreira et al. 2010).

Venezuela's moves toward democracy ran parallel with efforts by the state to capture a greater share of oil rents, beginning with legislation introduced by Medina Angarita (1941–45), successor to López Contreras. Initiated during a period of high US strategic dependence on energy imports, the 1943 oil law unified the fragmented concessions regime and established that foreign oil companies could not make greater profits from oil than they paid to the Venezuelan state. Royalties were increased to one sixth part of production in cash or crude oil and new income taxes on oil production activities were introduced. This increased by 77 per cent the fiscal income per barrel paid to the Venezuelan state in a period of increased oil production during World War II. Of significance to the economic crisis of the 1970s, the legislation set out that concessions would revert to the state after a forty year period (Mommer 1986).

Table 1: Venezuelan oil production

Year	Barrels per day	Oil price per barrel
1936	422, 512	0.88
1937	508, 916	0.96
1938	515, 178	0.93
1939	560, 368	0.80
1940	502, 270	0.93
1941	621, 319	0.98
1942	405, 904	1.01
1943	491, 463	1.03
1944	702, 288	1.05
1945	886, 039	1.06

Source: Toro Hardy (1992)

Medina Angarita continued political liberalization and increased state investment in public provision, including the creation of a basic social security system in 1944 based on state, employer and employee contributions. His term was ended by a progressive military coup that brought an AD led civil-military junta to power in 1945. During this brief democratic interlude known as the *Trienio* (1945–1948) the AD government proceeded with a radical programme of political, land and education reform. The Constitution of 1947 established for the first time the responsibility of the state for public health, with Article 51 setting out curative and preventive obligations and Article 52 outlining the right of Venezuelan citizens to protection from ill health and disease. Building on the tripartite framework for social insurance introduced in 1944 and expanded in 1946 with the creation of the Venezuelan Social Security Centre (*Centro Venezolano de los Seguros Sociales*, CVSS), the 1947 Constitution required state

contributions to an expanded system of social security, and it outlined the state's responsibility to provide for those of low economic resources.

Investment in public hospitals provided a safety net for those outside the formal labour sector that did not have access to CVSS coverage, hospitals and medical facilities. The National Hospital Plan of 1947 had a construction target of 22 hospitals and 48 health centres within a ten year period, increasing the number of public hospital beds to 9,000 from 610 in 1947 (Kornblith and Maingon 1985). Financing this "sowing" of Venezuela's oil income into the national economy and public provision was an amendment to oil legislation in 1947 that introduced the principle of 50-50 profit sharing between the state and the oil corporations. This increased the contribution of oil taxes to national revenues from 35 per cent of income in 1938 to 65 per cent by 1948 (Toro Hardy 1992).

The speed of social and political change during the *Trienio* alienated military, elite and clerical interests culminating in a coup in 1948 and a ten year dictatorship under General Marcos Pérez Jiménez. This was a period of political repression but accelerated economic expansion during a "golden age" for oil revenue owing to conflict in Korea, nationalization of the Iranian oil sector and closure of the Suez Canal. Average annual per capita income in Venezuela increased from $322 in 1949 to $530 by 1953, ahead of Japan ($197), Brazil ($215), Saudi Arabia ($100) and South Korea ($70) (Toro Hardy 1992). The population also rose driven by a rise in immigration and demographic expansion underpinned by improved health outcomes.

On the back of annual economic growth of 10 per cent, investments were made in housing provision, transport infrastructure, national electrification and heavy industry in line with the General's vision of a New National Ideal. The right to health was not included in the Constitution of 1953. However, disease prevention and public education campaigns were funded, with a focus on gastroenteritis and pneumonia following from the success in tackling malaria. Public hospital construction continued and significant revenues were allocated to projects in sanitation and school building. Like the pre-*Trienio* military governments, Pérez Jiménez was unable to contain pressure for democratization, while the corruption and brutal repression that characterized his regime forged a civil-military coalition that succeeded in removing the General in January 1958.

The Punto Fijo State 1958–1998

Venezuela's transition to democracy was made possible by previously conflictive parties formulating a consensus on future democratic governance through the 1957 Pact of Punto Fijo (Levine 1973 and 1985). This was signed by the leading political parties AD, the Christian Democrats (*Comité de Organización Política Electoral Independiente*, COPEI) and *Unión Republicana Democrática*; representatives from the Roman Catholic Church; the main trade union confederation; the military; and leading private sector groups. Radical left PCV and pro-Pérez Jiménez elements that were deemed antithetical to centrism were excluded.[6] The Pact committed signatories to a minimum programme of government configured around respect for the constitutional order, a national unity administration and a role for the state in social and national development (Buxton 2001; McCoy and Myers 2006).

[6] Alexander 1982; Karl 1987; McCoy 1988; Molina and Pérez 1998.

There was recognition that the democratic collapse of the *Trienio* period was linked to the AD government's accelerated social reform process, which had failed to respect corporate autonomies. Under the 1957 Pact, these were to be mutually guaranteed through an administrative spoils system that safeguarded the vital interests of labour and business, and "exit guarantees" of generous budgets for the Church and the military (Levine 1981; Trinkunas 2011).

Crucial to the Pact and related agreements was the commitment of COPEI but more specifically AD to control the mass base of their party organizations and affiliated unions. Under AD pressure and in the "democratic interest", organized labour recognized wage restraint and private sector property rights and this was reciprocated by business through its participation in the tripartite corporatist system created by the *Avenimiento Obrero Patronal* of April 1958. This elaborated the network of interest protection set out in the Pact of Punto Fijo by establishing collective bargaining as the only mechanism through which labour could lobby for sectoral demands. Job security, retention of the 1936 insurance system of monetary indemnity for sickness or accident, and extensive labour protection for public and private sector workers was balanced by state subsidies and tariff protection to the private sector, which had previously been reticent to implement progressive labour and social insurance legislation (Hellinger and Melcher 1998). Importantly, these agreements focused on the formal labour sector, which was largely organized in the AD affiliated *Confederación de Trabajadores de Venezuela* (Confederation of Venezuelan Workers). The distribution of welfare benefits was therefore configured around a co-opted social sector, which was privileged over informal sector workers and rural employees.

Oil export revenues facilitated these agreements, framing a positive sum game of state-led petroleum rent *distribution* that precluded the need for *redistribution* from one class to another through, for example, a progressive income tax. The generosity of this system and its promise of national progress for all welded popular affiliation to the highly centralized COPEI and AD parties, which in turn rolled out an extensive system of social policy provision.

The 1961 Constitution guaranteed public health care in Article 76 and the MSAS maintained responsibility for the planning and implementation of national health strategies. Public health care was seen as a motor of development and social justice in the new democratic period, with initial priority given to expanding medical access and vaccination campaigns in rural areas in line with the Agricultural Reform programme of the first AD government, and concerns over Cuban inspired rural insurgency (Ellner 1988). 436 rural clinics and 124 specialized rehydration centres were constructed and, in conjunction with preventive health initiatives, this increased life expectancy by 5.6 years between 1958 and 1961, from 53.6 to 59.2 years. Life expectancy in urban areas improved at a slower 2.5 years to 65.8 years. By the mid-1960s, the MSAS was responsible for 59 public hospitals with a capacity of 13,090 beds, while private provision accounted for 2,770 beds. The expansion of the public hospital network improved the ratio of beds to population to 3.5 per 100,000 in 1963 contrasting with 2.9 in 1950 (Kornblith and Maingon 1985). These figures do not include Venezuelan Institute of Social Security (*Instituto Venezolano de los Seguros Sociales*, IVSS) and military hospitals and medical facilities; the former expanded by the 1966 Social Security law that increased the number of workers and employers contributing to the obligatory scheme, with a one third top-up payment by the state, and which extended sickness coverage from short term illness and pregnancy to long term incapacity benefits and funeral payments.

According to Di John (2009:176) there was a transformation in development strategy between 1960 and 1973, characterized by a move away from the "relatively liberal" trade policy of 1920–58 to one driven by state–created rents and structured around protectionist tariff and non-tariff barriers. Keynesian based policies of sowing oil revenues into other areas of the economy were informed by the need to address national development commitments and unemployment, which by 1963 had risen to 13.9 per cent from 7.8 per cent during the democratic transition (Baptista 1997). State-led, export-focused development pursued from the mid-1960s was regionalized in strategy and focused on heavier, large scale industrial sectors such as mining, basic and non-metallic minerals and chemicals. It was supported by state enterprises such as the *Fondo de Exportaciones* (Export Fund), the *Corporación Venezolana de Fomento* (Venezuelan Development Corporation), CORPOINDUSTRIA (Venezuelan Corporation for the Development of Small and Middle-Sized Industries) and *Corporación Venezolana de Guayana* cohering within the five year plans of the National Planning Office (CORDIPLAN), which was established in 1959.

During this period, heavy industry's share of total output rose from 26.8 per cent in 1961 to 40.6 per cent by 1971, with nearly half of the rapidly urbanized economically active population employed in manufacturing, construction, commerce or the vast public sector bureaucracy. This was a period of dramatic change to occupational structure. Agricultural employment, which had accounted for 44 per cent of the labour force in 1951, fell back to just 25 per cent by 1971, while the number of petroleum sector employees declined from 45,000 to 23,000 over the same period. However, as a result of a young population and increased education provision, the total population in the labour force declined, from 34 per cent in 1950, to 32 per cent in 1961 and 30 per cent by 1971 (Allen 1977:141). New and generous Social Security legislation was introduced in 1967 with Centro Venezolano de los Seguros Sociales provision covering approximately one third of the labour force employed in the formal private and public sector though state, employer and employee contributions (Amparo Cruz-Saco 2002).

Economic boom and welfare declines

By 1970, Venezuela appeared to have achieved a consolidated democracy. It was the region's fastest growing economy and richest country and one of the twenty wealthiest countries in the world, with a per capita GDP only 13 per cent lower than that of the United Kingdom. However, there were distortions in the political economy of the country and these were grossly exacerbated by two massive exogenous shocks to revenues in 1973–4 and in 1981. Before addressing the impact of the resulting economic boom and bust, two structural weaknesses that exacerbated the negative impacts of the oil shocks can be identified. These relate to the Pact of Punto Fijo and changes to industrial development strategy, particularly as this related to the oil sector.

The legitimacy of the Pact of Punto Fijo and system of AD and COPEI dominated *partidocracia* (Coppedge 1994) was contingent on popular access to oil revenues, which were increased to a 60 per cent share for the state under the Sovereignty Decree of 1958. According to Hellinger (2000), the Pact established the political parties as the institutional channel for the distribution of oil rents, with the effect that the party system was dependent on accruing all differential rents available. This locked Venezuela into a structure of rent maximization at the cost of productive investment. In order to capture a greater share of oil revenues amid a growing concern over the finite nature of the oil resources, the strategy continued to be one of increasing tax and royalties on the private oil sector, without permitting an increase in production or granting of new concessions.

AD and COPEI administrations were under constant pressure to increase capital and current spending, social expenditures for example increasing from 17 per cent of the budget in 1962 to 33 per cent by 1973. The resulting loss of financial management generated fiscal deficits and the contraction of public debt by the end of the 1960s.

The second arm of the energy strategy was to boost international oil prices by forming a cartel with other oil producing nations, resulting in the creation of the Organization of Petroleum Exporting Countries (OPEC) in 1960. This decelerated private sector investment in Venezuela's oil industry, which fell by a third between 1957 and 1963 (Baptista 1997), including private oil companies running down welfare provision in the oil camps. As the private oil companies began a retrenchment of their position, Venezuela took steps toward nationalization with the 1971 Law of Reversion. This set out that all assets, facilities and equipment belonging to oil companies would pass to the Venezuelan state without compensation when private concessions expired. Nationalization followed in 1976 with. Petroleum Venezuela (*Petróleos de Venezuela, S.A.*, PDVSA) established as a holding company for the nationalized subsidiaries, "with the right to transfer 10 per cent of pre-tax profits from exports of its producing subsidiaries to its own coffers" (Hellinger 2000:10).

Venezuela was moving in the direction of nationalization when it experienced the first economic shock in 1973–74. As a result of the Yom Kippur war and Middle East oil embargo, there was a six-fold increase in the price per barrel of Venezuelan oil exports with a resulting increase in central government revenues of 34.5 per cent of the 1973 GDP. On the back of an apparently new golden age for Venezuela, nationalization positioned the state to capture the full financial benefits of the second oil boom of 1981, catalyzed by the conflict between Iran and Iraq.

> From 1974 to 1985, the increase of oil prices above their 1960–1973 average contributed an additional 523 per cent of 1973 GDP to a government that traditionally occupied 18–20 per cent of the economy. These figures do not account for the additional profits retained by the oil sector which then had an indirect impact on government revenues through spending in the nonoil sector (Moreno and Shelton 2013:3).

Following the surge in oil revenues, President Carlos Andrés Pérez (1974–79) sought to construct "El Gran Venezuela" directed through the Venezuela Investment Fund (*Fondo de Inversiones de Venezuela*). Between 1974 and 1977, government spending increased 26 per cent per year. Financing was ploughed into "state-owned, enterprise-led, natural resource-based, big-push heavy industrialization policy … in an attempt to vertically integrate the import-substitution process and to improve the technological capacity and diversification of the industrial and export sector" (Di John 2009:177).

Domestic demand (and the political legitimacy of the *partidocracia* model) was stimulated by generous multiple minimum salary increases; an extension of subsidies on transport, rented housing, food and medicines; new state contributions to social security, unemployment insurance and national housing credits; bonuses for vacations and childcare; and generous labour provisions that included double indemnification for dismissed workers, seniority payments and decrees prohibiting the dismissal of low-paid workers under the 1974 *Ley Contra Despidos Injustificados* (Law Against Unjust Dismissals). In terms of welfare spending during this boom period, in education, Ortega and Pritchett (2013:3) found that "by nearly every measure of the growth of 'schooling

capital' Venezuela ... outperformed other countries". Between 1972 and 1980, the number of public secondary schools increased from 200 to over 1,000.

However, extending the welfare model in the context of economic boom served only to complexify existing bureaucratic arrangements, as evidenced in health care, where diversified lines of responsibility and tributary provision – for example between the MSAS, IVSS and Ministries of Education and Military Social Provision exacerbated fragmentation (González 2006).

> The oil companies and other large foreign firms provided clinics and other medical services of their own, a practice used as well in some universities …. Life insurance and the system of HCM [Hospitalization, Surgery, and Maternity] were commonly contracted with private insurance companies with their own bureaucracies. Many of these provisions were included in collective bargaining contracts. Workers in these sectors, generally among those with the highest incomes, were separated in this way from the general system of social solidarity. The rest of the population remained subject to social security, if they had a responsible employer. That is, if an employer diligently deposited the quotas corresponding to the employee and the business to the fund. The sums fixed were very small, and it is well known that the financial discipline shown toward IVSS was very low. IVSS served only a restricted part of the workforce; with respect to medical attention it did little more than provide care in its own clinics in the largest cities (Hellinger and Melcher 1998:13)

To bust

Windfall oil revenues were chronically mismanaged, with successive administrations incapable of restoring fiscal stability or reigning in state intervention and the excessive corruption that was institutionalized by the Punto Fijo model.[7] The overvaluation of the domestic currency resulting from oil exports was a stimulus to imports, undercutting the domestic manufacturing and agricultural sectors, which were in turn unable to substitute for a decline in oil export revenues when the international oil price fell back.

As a result of the unpalatable political costs of reorienting the role of the state and reducing expenditures, there was profound reticence to adopt adjustment measures. When these were imposed, they were always temporary with a lift in the oil price prompting reversion to more politically expedient expansionary measures financed through a running down of international reserves, devaluations of the national currency, national treasury raids on the investment funds of the state oil company PDVSA and the contraction of debt. Between 1975 and 1978, indebtedness increased from less than 7 per cent to almost 35 per cent of GDP. Between 1979 and 1982, taking in the second boom of 1981, the debt to GDP ratio rose to 40 per cent, climbing throughout the decade to 74 per cent by 1989.

Inflation and recurrent balance of payments deficits resulting from overstimulation of the economy in the early 1970s became serious problems. State investment in manufacturing, heavy industry and agriculture was insufficient to meet demand and the quality and choice of investment areas was poor as a result of centralized planning through CORDIPLAN and the distorting effects of corruption and clientelist networks. As a result of underinvestment in the oil sector, production collapsed falling by almost a quarter in 1975. Between 1970 and 2000, there was a 64 per cent fall in per capita oil production, while per capita fiscal oil revenues fell to a third of their 1970 level by

[7] Di John 2009; Hausmann and Rodriguez 2013; Karl 1987 and 1997; Salamanca 1997; Toro Hardy 1992.

1990. The turmoil of Venezuela's oil sector was exacerbated by exploration for non-OPEC reserves, with new technologies facilitating activity in new areas such as the North Sea. Increased energy efficiency and development of non-hydrocarbon energy sources by oil importing countries added to downward pressures on the Venezuelan basket of crude. In 1982 alone, oil fiscal revenue per capita fell by 25 per cent.

By the late 1970s, Venezuela was recording an upward trend in poverty rates as a result of declining wage levels and the unequal distribution of wages. Despite the fall in real wages, unemployment also increased due to low levels of productivity and inflexible labour markets. Here Venezuela's experience went against the model of increased human capital leading to the improved productivity. This was due to:

> a serious problem in making effective use of its labour force …. The government kept up pressure to maintain high employment, even with unused capacity, and labour unions pushed hard to keep their workers on the payroll …. Firms hired workers but underutilized them because output failed to expand sufficiently to make effective use of them (Allen 1977:145).

Paralleling this problem was the weakness of the SME sector, which was crowded out by the state, uncompetitive due to the overvalued exchange rate and lacking entrepreneurialism.

> As the massive inflow of petrodollars made profits increasingly unrelated to production, money making as a goal became an independent activity, an end that defined its own means …. It involved a shift away from the ensemble of values associated with capitalist production toward those related to commercial and financial speculation …. Quickness, adaptability, and improvisation were valued over constancy, continuity, and discipline (Coronil 1997:318).

At this juncture, the welfare state model was incapable of providing an adequate safety net for the population and the impact of corruption and rent seeking behaviours that had surrounded state investment and autonomous enterprises became evident. For example, the Agricultural Marketing Corporation (Corporación de Mercadeo Agrícola, CORPOMERCADEO) sold food intended as a child malnutrition programme to private restaurants, at vast personal profit to the Corporation's president. Similarly, the Venezuelan Workers Bank (*Banco de Trabajadores de Venezuela*) that was established in 1966 to provide housing credit was intervened in 1982 as massive internal corruption linked to its president were revealed. Autonomous institutes and ministries such as the national and regional investment funds the *Corporación Venezolana de Fomento* and *Corporación Venezolana de Guayana* had serious liquidity problems as a result of autonomously contracting international debt while the IVSS was similarly bankrupted as a result of inefficiency, corruption and the use of its reserves for Banco Central de Venezuela deposits and the purchase of government securities (Buxton 2001:36; Hellinger and Melcher 1998).

The failure to rethink the organization of health care institutions inherited from the military era, particularly fragmentation between the MSAS and IVSS was a factor in the public health crisis of the 1980s. Kornblith and Maingon (1985) point to early problems of dysfunction and duplication both within the IVSS, and between the IVSS, welfare subsystems and ministries with overlapping responsibilities such as Health, Labour and Education. As lines of accountability for "integrated" health and welfare provision became fragmented, responsibility for public health and preventive campaigns lacked coordination. Complicating this situation was the tendency for governments to create autonomous enterprises and off-budget discretionary vehicles for welfare initiatives.

According to Kornblith and Maingon (1985), this institutional confusion accounts for the rise of preventable diseases as the primary cause of infant and adult mortality during the oil boom of the early 1970s.

Further problems included public health expenditure patterns, which by the end of the 1960s accounted for a sizeable 8.6 per cent of the national budget. Resources were invested in curative rather than preventive health care, and there was a surge in investment in expensive capital projects with related recurrent expenditures. This led to a centralization of medical facilities, expertise and hospital beds in large urban centres with concentrations of workers covered by insurance schemes, for example Caracas, where 23.6 per cent of hospitals were located by 1978, and Zulia where 11.9 per cent of hospitals were located. This was to the detriment of health care and disease prevention in rural areas, underscored by the 40.5 per cent of trained doctors being located in Caracas. Fragmentation of health care provision across different ministry lines further eroded coherent social planning.

An additional drain on the public health budget was the proportion of spending ring-fenced for salary payments to organized medical professionals and to officials and administrators within the vast bureaucracies of the IVSS, MSAS and related health quangos and autonomous institutes. Estimates place this in a range of between 50 to 70 per cent of spending, with the AD linked union movement in the health sector acting as a powerful and influential drag on reallocation of expenditures. As investment in preventive, quality and complex health care needs deteriorated during a period of increased social spending in the early 1970s, there was growing demand for private provision and a rise in out-of-pocket health expenses. Indicative of an increased reliance on private provision, the sector expanded from 12.4 per cent of hospital beds in 1963 to 22.8 per cent by 1979 (Kornblith and Maingon 1985). Particularly acute was the sclerosis of the IVSS. Rising unemployment meant a decline in the percentage of the labour force contributing to the health schemes administered by the IVSS, while the number of beneficiaries per contributor increased due to large numbers of dependents. The end result was that by the mid-1990s, the IVSS was unable to cover an estimated one third of its outlays.Parallel patterns of distorted and poor quality provision, bureaucratization and privileged salary and pensions for unionized public sector employees were evident in the education sector, which by 1979 was allocating 38 per cent of the total education budget to University level education even though this accounted for just 7.4 per cent of student numbers in 1975. As with the experience in health care, improvements in expanding access at pre-school, primary and secondary level in the early 1960s was reversed as increased budgets failed to respond to educational need and demographic change. For the period 1979–1980, it was projected that 600,000 children of primary school age, 334,000 children aged between 7 and 12, and 439,000 between 13 and 15 years were outside of the formal education system (Kornblith and Maingon 1985). There were serious issues in relation to the quality of education delivered by the country's powerful national teaching unions. For Ortega and Pritchett (2013) the increase in schooling reported in the 1960s and early 1970s "should have led to wages 25 per cent higher from 1975 to 2003—but in reality the average wage fell by 49 percent". Moreover the wage premium associated with having a college education or higher fell by 34 per cent between 1978 and 1982.

There was acknowledgement of the need to respond to serious issues of corruption, bureaucratization and fragmentation of public provision, however proposals to rationalize health care (1987, 1996) and the IVSS (1992, 1998) floundered amid pressure from AD affiliated health and education unions on the one hand, and a new generation of pro-market liberals in AD but more particularly COPEI pressing for

decentralization of Venezuela's heavily centralized unitary political system and model of public provision on the other. This latter position accorded with that of the IFIs, to which AD president Carlos Andrés Pérez was forced to turn when he was re-elected in 1988, when approximately 54 per cent of Venezuelans were already living in extreme or critical poverty and without access to basic medical services.

The structural adjustment experience

Latin America had the earliest experience of SAPs, with Chile emerging as a "laboratory" for neoliberalism during the military dictatorship of General Pinochet. The literature on the period of SAP application highlights achievements in terms of economic growth, which averaged 3.2 per cent in the first half of the 1990s, reduced levels of inflation and borrowing costs, and enhanced competitiveness in the export sector. However, this growth was not pro-poor and average per capita incomes remained below the level of the 1970s. Poverty reduction was slow; there was a trend of rising unemployment, an increase in informal sector employment from 25 per cent of the economically active population in 1980 to 32 per cent by 1990, and a decline in average real wages (CEPAL 1992). Highlighting the ensuing regressive redistribution of income that followed, O'Donnell argued that:

> The social situation of Latin America is a scandal. In 1990, about 46 per cent of Latin Americans lived in poverty. Close to half of these are indigents who lack the means to satisfy very basic human needs. Today there are more poor people than in the early 1970s: a total, in 1990, of 195 million, 76 million more than in 1970. These appalling numbers include 93 million indigents, 28 million more than in 1970. The problem is not just *poverty*. Equally important is the sharp increase of *inequality* in most of the region …. The rich are richer, the poor and indigent have increased, and the middle sectors have split between those who have successfully navigated economic crises and stabilization plans and those who have fallen into poverty or are lingering close to the poverty line (O'Donnell 1996:1).

In terms of health, Laurell (2000) points to a two-phase process of dismantling public provision, starting with reductions in state funding and decentralization of service delivery, followed by the privatization of management and delivery. The rationale for this strategy was articulated in the influential 1993 World Bank *World Development Report: Investing in Health*. Chapter Three discussed the limitations of the state's role in the provision of health care, including governments misjudging how interventions work in practice, lack of capacity to implement policies well, and capture by special interest groups within and outside of the health care system. It recommended that public health care should be limited to basic services targeted at the poor, while national government should improve national health care through decentralization of government services, promotion of competitive procurement practices, the fostering of greater involvement by nongovernmental and other private organizations, and regulation of insurance markets. These recommendations were endorsed by the Inter-American Development Bank, which supported initiatives to increase private sector involvement in health care and for-profit health insurance plans through loans and technical advice to Latin American countries.

Critics of this new direction argue that the strategy of marketizing health needs was influenced less by a preoccupation with popular health than prioritization of debt repayment

and transnational corporate interests.[8] Homedes and Ugalde (2005:86) argue: "With the exception of Chile and Colombia, technical, logistic, political, and financial problems have surfaced everywhere". The "reforms" were "truncated", producing confusion while forcing countries to waste scarce resources through lost economies of scale. In particular, IFIs failed to acknowledge "factors that need to be in place to enable a successful implementation of some components of the reforms", most specifically relating to decentralization and regulatory capacity. Their conclusion was that "multiple abuses and exclusions ... has been the rule more than the exception in Latin America". This observation holds for Venezuela's experience of health reform during neoliberal adjustment.

Venezuela's neoliberal experience

The changes to health care provision recommended by the IFIs were embraced by Carlos Andrés Pérez (1988–1992) and his successor Rafael Caldera (1993–1998), during the structural adjustment programmes *El Paquete* (1989) and *Agenda Venezuela* (1996) (Tulchin and Bland 1993; Naim 1993). Economic adjustment strategies aimed to reorient Venezuela away from oil rent dependence and toward a diversified and competitive export economy. Particularly contentious was the move to part-privatize PDVSA with a new round of tenders for exploration and production under the *Apertura Petrolera* (Oil Opening) led by PDVSA President Luis Giusti during the Caldera administration. Giusti internationalized PDVSA assets in order to preclude efforts by the national government to collect windfall taxes from the national company during this period of economic crisis.

Lending from the World Bank, the IMF (under a $4.8 billion three year extended fund facility) and the Inter-American Development Bank was conditioned on a transition to a more open economy, including liberalization of exchange and interest rates, reduced subsidies on state produced goods and services, and decentralization of health care and insurance provision. The World Bank provided $54 million to four of Venezuela's 23 states impacting three million users of public health services. The focus on just four states was informed by concerns that weak institutional capacity would "retard project execution", a risk mitigated by "focusing activities on a handful of states with the strongest political backing for decentralization" (World Bank 1994: iii). The Inter-American Development Bank supported a parallel programme.

In line with Homedes and Ugalde (2005), Venezuela fundamentally lacked an enabling environment for decentralization, which was introduced in 1989 amid mounting political and economic crisis. Andrés Pérez broke with a long tradition of state centralization by introducing decentralized services to state governments, who for the first time were to be democratically elected rather than presidentially appointed. This and accompanying reforms to the electoral system were intended to offset the fracturing of the Punto Fijo social contract of AD and COPEI hegemony in exchange for popular access to oil rents. The measures failed to arrest a terminal crisis of *Puntofijismo* that was manifest in high rates of election abstention, large scale social protests (including the violent *Caracazo* protests the day *El Paquete* was announced), two military coup attempts in 1992 (with one led by Lt. Col. Hugo Chávez), the impeachment of Andrés Pérez in 1993, and, by the end of the decade, the rise of non-traditional political options for the 1998 presidential contest, including Chávez.

[8] Homedes and Ugalde 2005; Jasso-Aguilar et al. 2004; Muntaner et al. 2006.

Decentralization fundamentally failed to improve the quality of public services or Venezuelan democracy, with the initiative quickly neutered by AD and COPEI practices of parachuting national political figures into regional candidacies and forming alliances to block the rise of third party options (Buxton 2001). As acknowledged by the World Bank, the majority of state governors were reluctant to assume responsibility for decentralized health and education services, particularly given uncertainty over decentralization of financial resources. As argued by Homedes and Ugalde (2005), the assumption that decentralized authorities were responsive to local needs proved not to be the case, while the strategy of decentralizing to "capable" states served only to entrench inequalities in provision and fragmentation of health services in an already overly complex system. Hellinger and Melcher (1998:16) argue that budget reductions instituted under the adjustment programme led to the closure of many public health facilities, particularly in rural areas, while the introduction of user fees by state and local governments was "excluding in increasing measure the poor from access to health care".

President Caldera (1993–1998) inherited a critical economic situation manifest in the collapse of the banking system. This required Venezuela to turn once again to IFI lending, with elimination of the IVSS forming part of the resulting structural adjustment process known as the *Agenda Venezuela*. The government aimed to create a mixed system of private and public funds, however, by 1998 the "model" social security law remained unimplemented resulting in a vacuum of provision. Those that could muster the resources for private health care turned away from the chaos of the public sector and IVSS so that, by 1997, 73 per cent of health expenditures in Venezuela were private. This is not to suggest a two tier system of provision; rather Venezuela had a three tier system, with the wealthiest turning to the US for both complex and cosmetic treatments owing to the low standard of domestic private provision. The end result was that rather than rationalizing and improving access to health care, the measures increased inequity, exclusion and inefficiency.

Chávez, the Pink Tide and the Neoliberal Alternative

The Chávez administration (1999–2013) marked a dramatic change in approach to the provision of health care: and not just in Venezuela. Chávez was the first of a series of left of centre presidents to be elected across the hemisphere in the "Pink Tide" of the 2000s including in Bolivia, Ecuador, Brazil, Nicaragua, Uruguay and Argentina.

In discourse and orientation, the left of centre presidents, including Chávez, had parallels with West European social democrats of the post-war era. Like Beveridge, they sought to confront the "five giants" and reverse chronic poverty, inequality and social exclusion by having as the object of government "the happiness of common man". Of particular importance to the direction taken, the new left was a "non-traditional" agglomeration of social movements and political outsiders. As such, many of the "new" left presidents lacked the institutionalized linkages to formal sectors and the labour movement that characterized the social democratic left in West Europe and Latin America's mass parties of the 1940s.

In a vacuum of functioning and legitimate institutions and representative political parties, these non-traditional actors sought to instrumentalize social change through informal mechanisms that connected to the excluded and marginalized. While this led to their characterization (specifically in the case of Chávez) as populist or—at its most intellectually myopic—the "bad" left (Reid 2009; Castenada 2006), the reality of many Latin American countries was that the "classical" Schumpeterian or liberal model of

functioning parties mediating between an active civil society and insulated state had either failed, been discredited or did not match popular demands for representation and participation. Reconstructing society required reclaiming and then bringing the state back into social development through the active and wilful leadership of committed and radical executives, connected to an impoverished majority through the language of *el pueblo (people)*. This was a radical proposition in the US "backyard".

Relating to Huber's observation (2012) on the importance of international context to welfare outcomes, the end of the Cold War marked a major change in hemispheric relations and this provided an enabling space for the new Latin American leadership to engage in innovative thinking on social policy provision. US capacity to influence the politics and economies of Latin American countries, including through the IFIs, was diminished as a result of factors that included the strengthening of democracy as a global norm (precluding military interventions) and the "rise" of China, Russia and India in the global economy (reducing Latin American dependence on the US and eroding the utility of traditional tools of US influence such as preferential tariff rates). Indicative of the disjuncture in hemispheric relations, the US proposed Free Trade Area of the Americas was rejected by a majority of Latin American countries at the Summit of the Americas in Mar del Plata, Argentina in 2005.

Further contributing to a favourable international context for new social policy paradigms were the Millennium Development Goals and the emergence of sustainable development and human security frameworks, most importantly through the 1992 UN Conference on Environment and Development. This affirmed a right to healthy and productive lives that was restated at the regional level at the 1995 Pan American Conference on Health and Environment in Sustainable Human Development. The resulting Pan American Charter on Health and Environment in Sustainable Human Development and Regional Plan of Action required member states to address health needs by implementing measures in line with Charter and Action Plan. In a raft of subsequent Organization of American States (OAS) declarations, including the 2001 Inter American Democratic Charter, poverty and social exclusion were conceptualized as the drivers of insecurity, conflict and violence, in turn mandating national action by governments as a means of building hemispheric peace, democracy and development. This included, through formal commitments in the realm of health and education, provision in line with the 1995 Pan American Charter.

Following from the 2001 Summit of the Americas, Health and Environment Ministers of the Americas (HEMA) of the Member States of the OAS met on a routine basis starting in 2002 to deepen cooperation and develop institutional frameworks for regional and national level action on health issues and to "build bridges between the health and environment sectors to address common issues and strengthen countries' capacities to manage health and environment issues" (HEMA 2005:1).

A final enabling factor was recognition by the 2000s that inequality could not be addressed through targeted anti-poverty initiatives, and that without addressing the structural drivers of inequality, it would remain a drag on economic growth, development and democratic citizenship.[9]

[9] Alesina and Rodrik 1994; ECLAC 2002; UNDP 2004.

The importance of the Chávez administration lies in its efforts to translate declaratory principles into practice and to address the political as well as economic causes of inequality. In relation to health, the evolution of policy can be delineated into three phases, each influenced by political factors that serve as explanatory variables in understanding the drivers of government strategy.

Health and social policy under Chávez: Phase 1 (1999–2003)

The social panorama of the country that Chávez inherited was one of profound inequality, with the poorest quintile receiving three per cent of national income while the richest quintile captured 54 per cent. Over 60 per cent of farmland was owned by just two per cent of landowners and the country lacked food sovereignty, with resulting problems of malnutrition and illness due to the high cost of imported food. Half of the economically active population was employed in the informal sector, and just 23 per cent of the economically active population had access to the bankrupt and fragmented social security system. Moreover, oil had fallen to a record low of just $7 per barrel.

The period between Chávez's inauguration in February 1999 and the launch of the health care *Misión Barrio Adentro* (Into the Neighbourhood) in 2003 did not see significant innovation in health care or anti-poverty initiatives. The new government was focused on: a) constitutional and institutional change of the Venezuelan state; b) conflict with opponents associated with the previous Punto Fijo regime and; c) a major humanitarian crisis caused by floods in December 1999.

Chávez prioritized redrafting the nation's constitution. This was intended to create the legal framework for an ambitious project of institutional redesign, including in relation to the state's responsibility to its citizens. Fundamental to this Bolivarian vision was the notion of participatory democracy, a routine and "protagonistic" popular engagement in policy development, implementation and service delivery. The concept of protagonistic democracy saw political equality as fundamental to the realization of economic equality and vice versa. Where the top-down model of liberal democracy (and *Puntofijismo*) looked to minimize popular participation and insulate the state from social pressure, protagonistic democracy sought to create the conditions for routine participation and influence from the bottom up (Hellinger and Smilde 2011; Ellner and Tinker Salas 2007). This equalization of access and opportunity was seen to be contingent on full and effective citizenship provided for by an expansive and interventionist rather than slim and remote state.

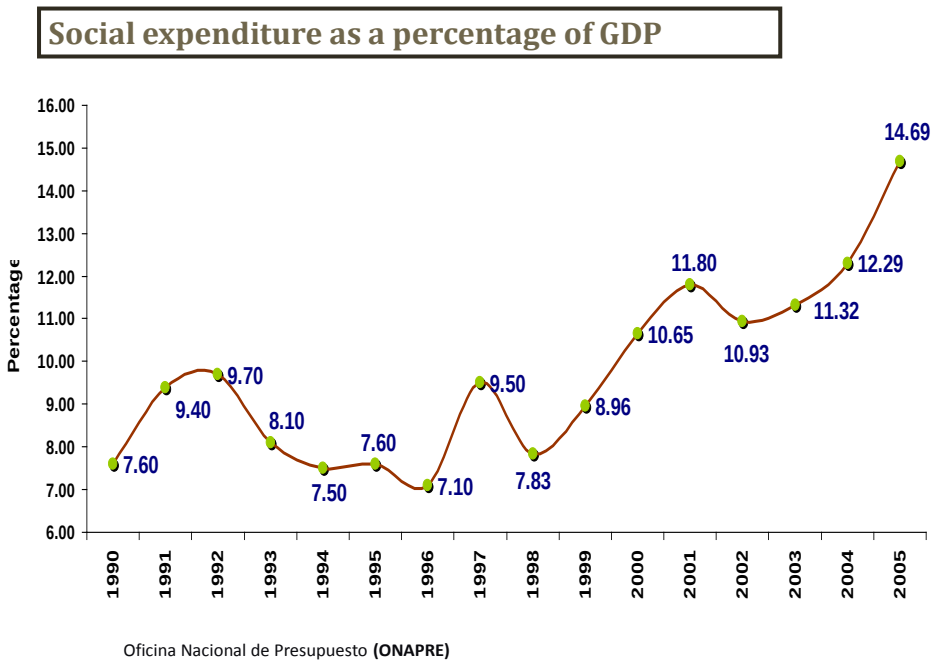
A new Constitution embodying these principles and designed by an elected Constituent Assembly received popular ascent in December 1999. It broke with the Punto Fijo era by establishing a new Fifth Republic, inspired by the (contested) values of Independence leader Simón Bolívar. This Bolivarian Constitution established health care, education, housing and social security as human rights guaranteed by the state. Under Article 83, it was the responsibility of the State to implement policies to improve collective social well-being, quality of life and access to health services, with citizens expected to engage in the promotion and defence of public health. Article 84 required the State to establish and administer an integrated, universal, decentralized, participatory and free public health service with guaranteed equity of access, while Article 85 established that the financing of health care was an obligation of the State with revenues raised from taxes, oil income and social security contributions. This Article also detailed the state's responsibility to regulate private as well as public elements of health care and committed the state to training health care professionals.

During this first period, the government sought to address the immediate financial and institutional barriers to health care while new Constitutional rights were being deliberated. After service charges for emergency services in public medical institutions were suspended by presidential decree, institutional reform focused on establishing a new Ministry of Health and Social Development (*Ministerio de Salud y Desarrollo Social*, MSDS) to replace the MSAS. The MSDS received an increase in budget resources, in addition to off-budget revenues from a dedicated social fund, the *Fondo Único Social*, financed by windfall oil income.

Influential within the MSDS was the social medicine philosophy championed by Chávez's Health Ministers Gilberto Rodrıguez Ochoa (1999) and Maria Lourdes Urbaneja (2001), the former previously president of the Latin American Social Medicine Association. This approach emphasized health as a social and a human right that could only be realized by addressing the political, economic and social determinants of ill health. The critical epidemiology perspective influenced the pursuit of integrated social development measures.

The MSDS was immediately engaged in developing strategies to improve access to health care resulting in programmes to update medical equipment in primary health care centres, the drafting of a *Model of Integral Health Care* and a reorientation of health spending away from curative and back to a preventive focus. The *Plan Estrategico Social* (Social Strategic Plan) of the MSDS, published in 2002, set out the framework for implementing constitutionally guaranteed health care rights.

Figure 1: Rising social expenditures in phase 1



Source: Venezuelan Embassy presentation, Washington DC

Reflecting the government's emphasis on an integrated approach to social development, this first phase did see initiatives in education. This included ending the system of half day primary education provision that was introduced during the early 1970s to address

rising student numbers, and replacing this with a full days teaching timetable. According to Aponte Blank (2012) this led to rapid improvements in the quality of education provision. The reform was supplemented by the Bolivarian schools construction programme, an ambitious nationwide project to build and equip an initial 400 schools. However, this only covered one third of demand, a gap that underlined improvisation in the government's initial response to deep seated problems of social exclusion. Similarly Plan Bolívar-2000 (PB-2000), a civil-military programme coordinated by the Ministry of Defence and which was conceived as a "social emergency programme" demonstrated the limited reach of ad hoc policy responses. Intended to focus on repairs to the physical infrastructure of the country financed by off-budget and *Fondo Único Social* funding, PB-2000 was quickly mired in allegations of corruption and claims Chávez was "militarizing" the country.

Phase 1 consequently marked limited advances in reducing Venezuela's profound social deficit. While this can be explained by the administration's primary focus on laying the constitutional foundations for change, its conflict with Punto Fijo opponents is also a significant explanation for the "fire-fighting" characteristics of this first phase and subsequent depth of provision in the second phase.

The traditional political elite in the AD and COPEI parties and their network of affiliated interests in the labour and business sector resisted the overhaul of the Punto Fijo states through destabilizing actions that included a coup attempt against Chávez in April 2002 and a paralyzing series of lock outs and strikes, including at the national oil company PDVSA in early 2003. These actions led to a steep contraction of the economy that increased the number of households living below the national poverty line, from 44 per cent of the population in 1998 to 55 per cent in 2003.

The conflict between the government and *Puntofijistas* was indicative of the resistance to those redistributive measures that were highlighted as necessary to address structural inequality. This included resistance from the US, which assumed an antagonistic position toward Chávez after he had declared his candidacy for the presidency, and endorsed the 2002 coup attempt against him. For the Chávez administration, overcoming opposition resistance was essential for it to progress its agenda of radical political and social transformation. This was particularly the case in relation to the conflict with PDVSA. The ruling Patriotic Pole alliance (*Polo Patriótico*) had rejected the *Apertura Petrolera* as illegal and the internationalization strategy pursued by Luis Giusti as contrary to the national interest. The Bolivarian Constitution of 1999 established state sovereignty over hydrocarbon resources, with majority PDVSA control of all oil related activities set out in the 2001 Hydrocarbons Law. PDVSA was condemned as a "state within a state" by the new government, which saw the oil company as operating at the service of US oil consumers rather than impoverished Venezuelan citizens. These arguments echoed the original concept of "sowing the oil" discussed in the first section of this paper. A restructuring of PDVSA senior management, alliances with OPEC hawks to lift the oil price and early efforts to bring PDVSA under the control of the Ministry of Energy catalysed the PDVSA lock out of 2002–03. This cost Venezuela an estimated $12 billion in lost oil export revenues. These class, political and intellectual conflicts of Phase 1 shaped and incentivized the radical approach of Phase 2.

Social policy under Chávez: Phase 2 (2003–2006)

Having come perilously close to overthrow and collapse during its first years in power, the Chávez administration sought to insulate itself from domestic and international (US)

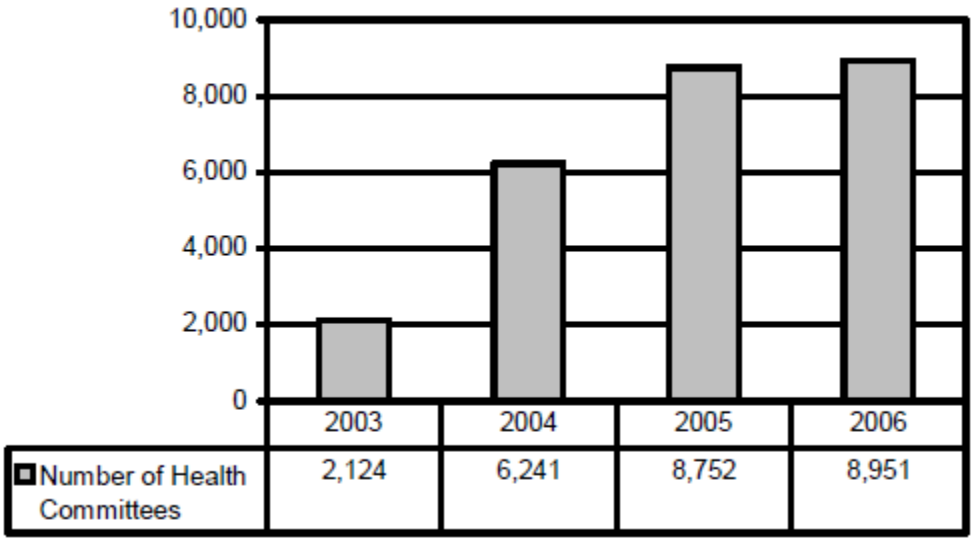
opposition by a three pronged strategy of a) consolidating its support base among marginalized and excluded sectors; b) developing new mechanisms to bypass a resistant *Puntofijista* state; and c) forging new foreign policy alliances. *Misión Barrio Adentro*, the key health care initiative that was introduced in 2003, represented a drawing together of these three strands in the government's strategy. It was shaped by the social medicine perspective on integrated and contextualized health care processes and the participatory thrust of the Bolivarian revolution.

The roots of *Barrio Adentro* were the devastating floods of December 1999 that in particular affected residents of Venezuela's informal housing settlements or *barrios* that ring Caracas. The Cuban government responded to the humanitarian crisis by providing 454 Cuban health care workers through its international solidarity program to *barrio* residents. A request that similar support to acute needs be provided by the Venezuelan Medical Association was rejected by unionized health workers on grounds of security and also as part of their affiliation to the opposition campaign against the government. The VMA's subsequent resistance to participation in plans to provide basic health care services in the *barrios* developed by Freddy Bernal, the *chavista* mayor of the Greater Caracas Municipality in 2002 led him to separately negotiate an agreement with the Cuban government for the provision of a small number (58) of specialists in family medicine.

The Cubans were initially housed with *barrio* volunteers and from this basis, community-led programmes were established that engaged residents in surveys of local health needs and support to the Cuban medics for example during house visits. The model was taken up by the national government, with the launch of a nationwide and multisectoral scheme—*Barrio Adentro*—in September 2003. The development and roll out of *Barrio Adentro* was overseen by a presidential commission that drew together health, defence, energy and PDVSA personnel, and the MSDS, with traction provided by a cooperation agreement between Venezuela and Cuba. Under this accord, the isolated and financially vulnerable Caribbean island provided Venezuela with over 12,000 medics, dentists, integral health specialists and medicines in exchange for 53,000 barrels per day of Venezuelan oil worth an estimated $2 billon on oil markets.

The initial focus of *Barrio Adentro* was the construction of integrated medical centres or *octogonales* in the *barrios*, providing *in situ* curative and preventive health care and training for community health workers, of which there were over 2,700 by 2006. This was overseen by nearly 9,000 community health committees organized by *barrio* residents and which included representatives from the MSDS and other institutions critical to integral, holistic health interventions including the national water company and education, housing and employment ministry officials. The health committees were overlaid onto other participatory initiatives introduced in Phase 2, that were designed to build protagonistic democracy through community-based decision making on issues ranging from education to recreation, infrastructure and housing needs (electricity, potable water etc.), most significantly the *Consejos Comunales* (Community Councils). The councils, which were determined by population ranging from 250 families in dense urban areas to 400 in rural localities, were the basis for allocating and locating medical centres, and they integrated the community medical committees into their structure and function (MSDS 2005).

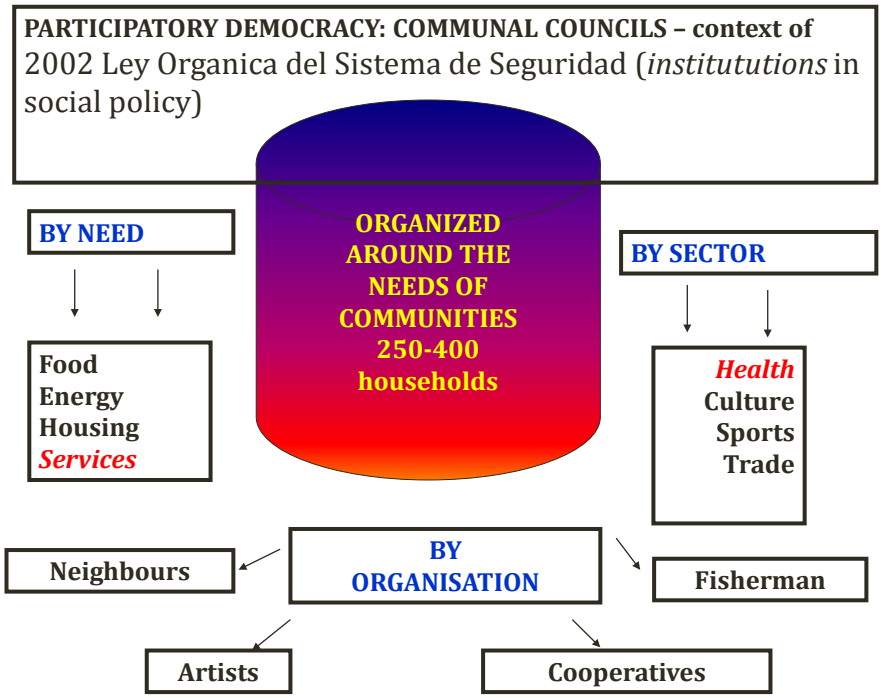
Figure 2: Number of health committees 2003–06



Source: Muntaner et al. 2008.

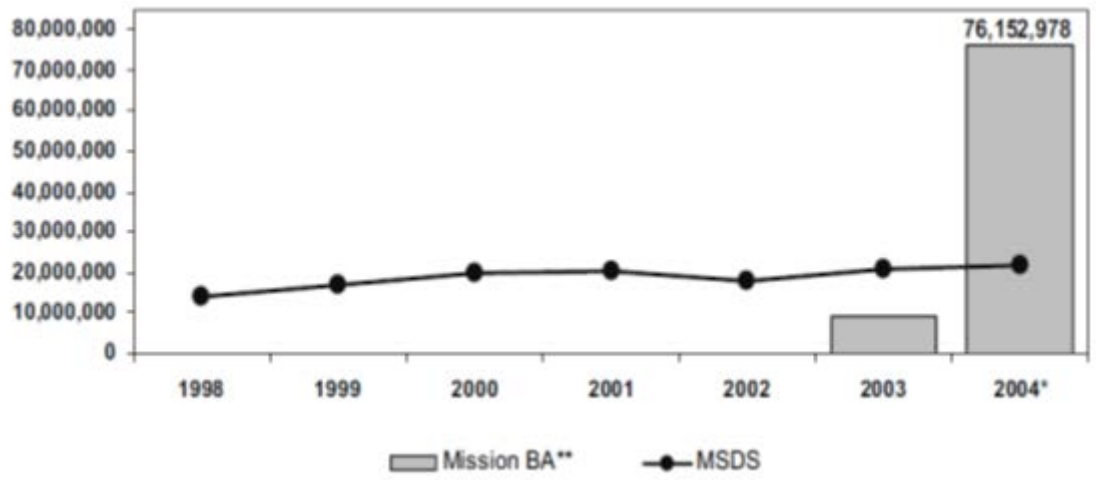
The councils, like *Barrio Adentro* itself, were a means of bypassing dysfunctional ministries and opposition-controlled local and regional authorities in order to enable popular participation in policy development and delivery. They functioned as a parallel state, later conceptualized as an alternative "geometry of power" that enabled direct as opposed to liberal democracy.

Figure 3: Community organization



The formation of a council medical committee was a prerequisite for provision of health clinics, engaging communities in proactive identification of health needs. In contrast to the cost ineffectiveness of locally purchased medical supplies during the neoliberal phase of health service decentralization, all medications were centrally purchased and they were distributed free of charge by the clinics and a network of popular pharmacies, including antiretroviral drugs and chemotherapy treatments.

Figure 4: Comparison of number of medical visits conducted by Ministry of Health and Social Development (MSDS) and *Barrio Adentro* (BA) 1998–2004

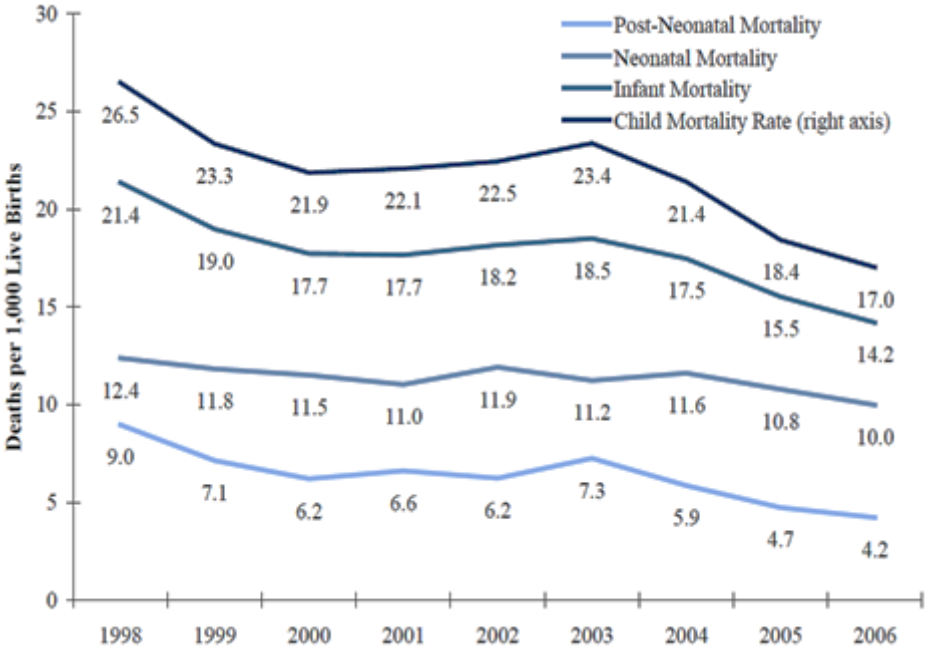


Source: Muntaner et al. 2006.

From these foundations, *Barrio Adentro* moved quickly to a second phase that addressed consolidation of the primary care initiatives through construction of an additional 6,000 community medical centres and provision of secondary treatment. This included a target of 600 specialized diagnostic and 400 linked rehabilitation facilities (*Salas de Rehabilitación Integral*), 35 high technology centres (*Centros de Alta Tecnología*), construction of a network of *Barrio Adentro* hospitals including 45 *Clínicas Populares* (small hospitals with capacity for elective surgery and intensive care), and training of Venezuelan health professionals ready to assume responsibilities from Cuban specialists. In response to the growing complexity of *Barrio Adentro* projects, the MSDS was divided into the Ministry of Popular Participation and Social Development (*Ministerio de Participación Popular y Desarrollo*) and the Ministry of Popular Power for Health (*Ministerio del Poder Popular para la Salud*) in 2005. This was financed by the government, which benefited from the doubling of the oil export price.

Barrio Adentro III, launched in 2006, began the integration of Venezuela's 300 public hospitals into the framework of the health mission, with targets for the construction of 18 specialized cancer treatment centres to address the second leading cause of male and female mortality in the country. *Barrio Adentro IV*, launched at the end of 2006, focused on the building of a dozen new hospitals, each with specialist areas of significance to national health needs such as cardiology. By the end of 2006, there were over 23,000 Cuban medics engaged in the delivery of *Barrio Adentro* projects, which covered 68 per cent of the Venezuelan population. Initial Pan American Health Organization evaluations indicated positive health outcomes including reductions in child mortality from diarrhoea and pneumonia, strong community engagement in health projects and a significant and rapid expansion in access to health care (Organización Panamericana de la Salud 2006).

Figure 5: Infant and child mortality rates during the Chávez administration



Source: Muntaner et al. 2006

Paralleling the development of *Barrio Adentro* were other social *misiones* created between 2003 and 2006 to address integral social development. Like *Barrio Adentro* these were financed by windfall oil revenues and they included the education programmes *Misión Sucre*, *Misión Robinson* and *Misión Ribas*; the job creation programme *Misión Vuelven Caras* and *Misión Identidad* that addressed documentation deficits and electoral registration (including of an estimated two million Colombians displaced from that country's civil conflict) and *Misión Mercal*. The latter provided a network of popular supermarkets providing basic food products at up to 80 per cent discount to ensure all citizens had access to daily calorific requirements. Two additional health *misiones* included the 2006 *Misión Milagro* (the Miracle Mission), which focused on ophthalmology and cataract treatment and which was introduced after the adult literacy programme *Misión Robinson* identified vision problems as an impediment to literacy. *Misión Sonrisa* (Mission Smile) supplemented the primary care dental services of *Barrio Adentro* with access to dental prosthesis through a target of 140 laboratories across the country.

The *misiones* were a novel institutional response to the obstructionism of state and regional level bureaucracies, which were dominated by placements of the traditional political parties. The key challenge facing the Chávez government was that having won power through democratic elections, it could not enact its authority. The *misiones* were a means of bypassing politicized and sclerotic bureaucracy while simultaneously canalizing popular demands and the constitutional requirement for participation in decision making. The *misiones* operated as parallel structures, or a form of dual government that were able to respond quickly to urgent social need through a multisectoral approach that maximized specialization and logistical capabilities. They served as an important linking mechanism to the government's project of building an inclusive "social economy" at the service of need and not profit through initiatives such as land redistribution and improved popular access to lending facilities.

Misión Mercal for example served as an outlet for the 6,000 agricultural cooperatives planned by the government following the redistribution of land from those that could not demonstrate private ownership as set out in the 2001 *Ley de Tierras* and implemented at an accelerated pace after 2003. The concept was of a virtuous circle that boosted rural employment, food sovereignty and popular access to low cost products, which in turn improved health and nutrition. These radical approaches to addressing inequity in the distribution of land, capital assets and political access in turn fuelled opposition hostility, sustaining a cycle of conflict and entrenching polarization.

Table 2: Poverty reduction

Venezuela: Poverty Rates, 1997-2007

Year /	Time Period	Households (% of total declared)		Population (% of total declared)	
		Poverty	Extreme Poverty	Poverty	Extreme Poverty
1997	1st Half	55.6	25.5	60.9	29.5
	2nd Half	48.1	19.3	54.5	23.4
1998	1st Half	49.0	21.0	55.4	24.7
	2nd Half	43.9	17.1	50.4	20.3
1999	1st Half	42.8	16.6	50.0	19.9
	2nd Half	42.0	16.9	48.7	20.1
2000	1st Half	41.6	16.7	48.3	19.5
	2nd Half	40.4	14.9	46.3	18.0
2001	1st Half	39.1	14.2	45.5	17.4
	2nd Half	39.0	14.0	45.4	16.9
2002	1st Half	41.5	16.6	48.1	20.1
	2nd Half	48.6	21.0	55.4	25.0
2003	1st Half	54.0	25.1	61.0	30.2
	2nd Half	55.1	25.0	62.1	29.8
2004	1st Half	53.1	23.5	60.2	28.1
	2nd Half	47.0	18.6	53.9	22.5
2005	1st Half	42.4	17.0	48.8	20.3
	2nd Half	37.9	15.3	43.7	17.8
2006	1st Half	33.9	10.6	39.7	12.9
	2nd Half	30.6	9.1	36.3	11.1
2007	1st Half	27.5	7.6	33.1	9.4
	2nd Half	28.5	7.9	33.6	9.6

Source: Weisbrot 2008.

Funding for the *misiones* was provided by improved income tax collection and most significantly oil rents and windfall payments, the latter soaring in 2003 and 2004 following the US invasion of Iraq. This links in turn to the final "outer circle" of the Bolivarian model, recast in 2005 as the construction of "twenty-first century socialism" which was the reconfiguration of energy and foreign policy.

Following the PDVSA lock out of 2002–03, over 10,000 staff were fired and replaced by sympathizers of the government. Similar upheaval and corporate reorientation was

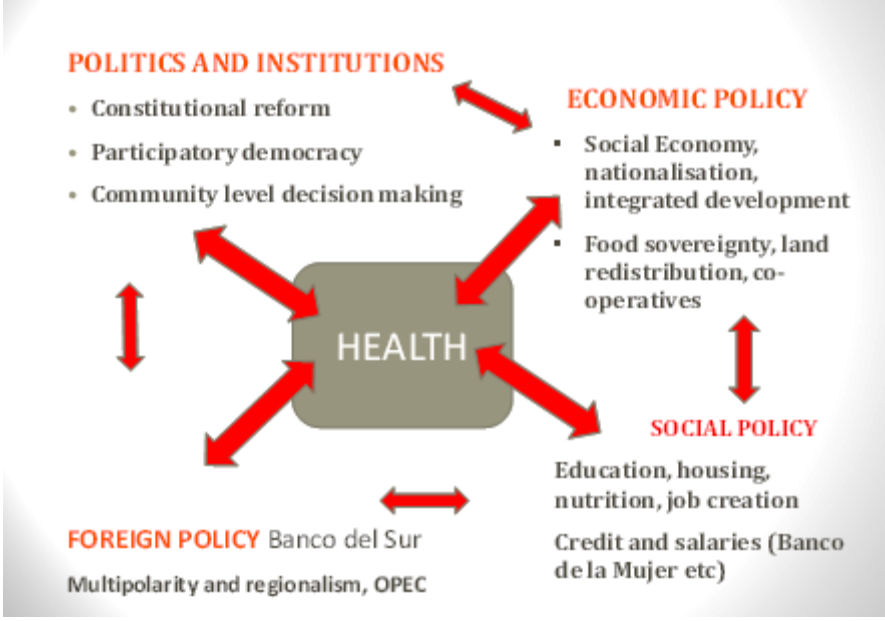
experienced in other "disloyal" institutions including the military and judiciary after the 2002 coup attempt. Having concluded that progressive social change could not be advanced without overcoming conservative resistance, the government assumed an aggressive model of state de- and then re-politicization. The new "People's PDVSA" was integrated into the social economy with the oil company contributing profits and staff to the construction of twenty-first century socialism.

Initially the Chávez government had come to power committed to diversifying the economic base away from oil rent dependence. As a result of the political confrontations of 2002 and 2003, there was a shift in perspectives, with the oil economy reconceptualized as the "motor" of the Bolivarian revolution. After 2003, the Chávez energy team crafted new international trade and energy alliances with non-traditional partners such as China, Russia and Iran, with the aim of exploiting the country's natural commodity advantages through bilateral commercial, technology and investment initiatives. These were intended to facilitate access to unconventional oil reserves in the Orinoco basin, guarantee new markets for Venezuelan oil products and lift the international oil price through output agreements.

The use of oil as a bartering commodity as exemplified with the "oil for doctors" programme with Cuba was extended to Central America and other Caribbean and Latin American countries through regional initiatives such as Petrocaribe and Petrosur. These projects, driven by the surge in oil export revenues accruing to Venezuela during Phase 2, were enabled by the region's leftward shift in the 2000s and they were built into regional integration initiatives that emphasized complementarities and social development over free trade, and Latin American unity to the exclusion of the US, as exemplified by the Bolivarian Alliance for Latin America (ALBA) that brought together Venezuela, Cuba, Bolivia, Nicaragua and Ecuador, and the Union of South American Nations, UNASUR. The latter was intended as a replacement for the US dominated OAS. It excluded the US and Canada and led by Brazil and Venezuela, sought to construct an alternative to IFI lending through initiatives such as the Banco del Sur.

Venezuela's energetic foreign policy during this period can be understood as a means of both defensively insulating the country from active US efforts to isolate Venezuela, and to proactively build an alternative to US and neoliberal dominance of the hemisphere. It was in line with the Bolivarian vision of a multipolar world order in which the unilateral influence of the US was diluted by the construction of alternative poles of power. The integration of these multiple policy strands and their relationship to health and social policy in Venezuela is represented in figure 6 below. At the domestic level, the commitment to addressing exclusion, poverty and inequality and delivered through the *misiones* enabled the government to consolidate its support base, allowing President Chávez to strengthen his position through defeat of the 2004 recall referendum and victory in the December 2006 presidential election.

Figure 6: Health policy in twenty-first century socialism



Source: Venezuelan Embassy presentation, Washington DC.

The final phase of social policy evolution identified offers a critique of the measures and mechanisms that were introduced by way of identifying limitations in terms of sustainability.

Phase 3: Neglect and deterioration

During Chávez's third term (2006–2012) the government accelerated efforts to create twenty-first century socialism. This was to the detriment of consolidating the achievements that had been made during Phase 2 and it led to an over-extension of the state and a resulting increase in dependence on oil export revenues. Having been the primary focus of government activity during the period 2003–2006, social policy slipped down the agenda of priorities, spending was reduced and emerging dysfunctionalities were not addressed.

The problems that were developing in the *misiones*, including those dedicated to health, related primarily to the challenge of reorienting spending and management functions from quantity of provision to quality. This required new mechanisms for specialist input, evaluation and analysis that were not adequately addressed, with emphasis instead maintained on non-specialist community participation. This was problematic given evidence of corruption, popular "fatigue" with routine political engagement and increased partisan conflict at local level driven by "hard core", ideologically committed *Chavistas* and their dominance of community level organization. The Community Councils, of which there were 23,000 by 2006, and linked organizations such as the Health Committees, reported problems of non-attendance by state and local officials who were meant to serve as the mechanism for articulating popular needs to ministries and channelling public spending. In the context of funding only being provided to organized communities, non-mobilization, disaffection and committee dysfunction impeded equity in resource allocation while raising complaints of clientelism and politicization (Pulido de Briceño 2001; Aponte Blank 2012).

A second significant issue not addressed in Phase 3 was the need to institutionalize the *misiones* and achieve a more effective integration between these unofficial initiatives, the state bureaucracy that they were designed to bypass and existing subsystems and insurance regimes to which formal sector workers and those with sufficient disposable

income continued to contribute to. In the absence of a strategy to unify disparate social policy mechanisms, inevitable problems of duplication and mismanagement emerged in a situation of dual government, while the pre-existing problem of fragmented services that the Chávez administration inherited was perpetuated. Moreover no progress was made in addressing the complex and inadequate system of social security or the IVSS, with the government side-lining major institutional and complex reform.

A third issue related to the fall in social spending after 2007 as the Venezuelan state assumed expensive responsibilities in other areas of the economy, and as the international oil price fell back amid the global financial crisis. Chávez's third term was marked by an accelerated pace of nationalization, driven by an increasingly assertive pro-Chávez labour sector and the government's response to blockages in production chains generating shortages of goods and services. The state assumed responsibility for key elements of the utilities sector including electricity, telecommunications and water, as well as heavy industry, energy, manufacturing and dairy production. This over-extension of the state was also informed by the decline of private sector activity, massive capital flight and a steep fall in foreign direct investment, which collapsed 60 per cent in 2002 to $1.3 billion (0.8 per cent). Thereafter, net foreign direct investment inflows as a percentage of GDP rose to 2.4 per cent in 2003, before contracting to an historic low of -0.9 per cent in 2009.

Table 3: Net inflows of foreign direct investment as percentage of GDP

1991	3.70
1992	1.08
1993	0.64
1994	1.44
1995	1.32
1996	3.20
1997	7.23
1998	5.46
1999	2.95
2000	4.01
2001	3.00
2002	0.84
2003	2.44
2004	1.32
2005	1.86
2006	0.11
2007	1.13
2008	0.13

2009	-0.92	
2010	0.20	
2011	1.65	

Source: Index Mundi[10]

Linked here was a fourth problem of growing disequilibrium between economic management and basic social services. While the (re)introduction of price and exchange controls and subsidies were effective in delimiting economic crisis and reducing poverty during Phase 2, their retention into Phase 3 generated strong inflationary pressures, inefficiencies and corruption in the dispersion of foreign exchange and an embedding of inequalities caused by regressive universal fuel subsidies. In relation to the latter, a government that saw itself as both radical and pro-poor maintained the costly and regressive $15 billion subsidy on domestic fuel consumption which kept Venezuelan petroleum prices at the lowest in the world. An inter-related challenge to sustainability was the dependence of the *misiones* and related poverty reduction initiatives on changing the pattern of oil rent distribution from the wealthiest and middle sectors to the poor, rather than redistributing national income through income taxes, the non-oil sector and elimination of regressive subsidies. This is not to suggest that oil rent financed social provision is not feasible. On the contrary, effectively managed commodity wealth can enable a rapid expansion of access to health and other social development needs. However in the Venezuelan case, the ongoing illusion of oil wealth led the government to over extend itself in other areas of the economy, at the cost of the significant welfare gains made during the period 2003–06. This made social policy provision vulnerable to declines in the international oil price, and the related collapse in oil production that followed from underinvestment by PDVSA. Arguably the availability of oil export revenues provided a means for the government to avoid costly political conflict with opponents and bypass the creation of a progressive income tax system. The end result was that dependence on the oil economy was embedded during Phase 3, contradicting initial government commitments to diversification of the economic base. In turn, the economy maintained its vulnerability to an overvalued currency, uncompetitive exports and rent seeking behaviours.

A final issue that was not confronted by the government was the catastrophic level of insecurity and crime that was most particularly suffered by *barrios* residents. Chávez inherited a serious problem of homicide and violent crime but his administration's most significant failure was its inability to develop a comprehensive response. A persistent turnover of officials in the interior and justice ministries, the fragmentation of policing and security services and the proliferation of small arms during the Bolivarian revolution pushed Venezuela up the global league of social violence, with the country ranked at number 4 in world indices of homicide during Chávez's tenure. This environment was wholly antithetical to community engagement and participation and it served as an inevitable drain on quality of life indicators and health budgets.

After a period of neglect, social policy did re-emerge as a key government priority in the run up to the October 2012 presidential elections and as the economy rebounded from recession between 2007 and 2010. In his campaign for re-election, a physically

[10] See http://www.indexmundi.com/facts/venezuela/foreign-direct-investment (accessed 14 November 2014).

ailing Chávez acknowledged the need for "rectification" of the *misiones*, which he set out as the primary objective of his fourth term. Over forty small *misiones* were introduced during this latter period but these were limited in coverage and ambition and they patched up rather than holistically addressed weaknesses in the existing model of social provision and poverty reduction. Chávez triumphed in October, but his death from cancer at 58 in March 2013 left the issue of reform and consolidation under his successor Nicolas Maduro open to question.

Conclusion

This paper has highlighted the institutions, actors and processes that have driven social policy provision and health care in Venezuela during distinct political periods. The historical detail contextualizes a protracted struggle over the distribution of the country's oil "wealth". The paper concurs with the importance of democracy, political will and a favourable international context in driving public access to health care, but emphasizes that situations of institutional and political decomposition as inherited by President Hugo Chávez require literatures and policy makers to engage with non-traditional mechanisms for articulating and responding to health care needs, and the importance of avoiding the temptation of writing these off as crude "populist" experiments.

The case of Venezuela illustrates the significant challenge of peacefully addressing the political roots of social inequality and the obstacles that can be posed to improving access to health and social development by conservative opponents and vested interests, including in the trade union movement and nominally social democratic parties. It calls attention to the importance of moving beyond liberal democratic and free market schemas in order to engage the participation of local populations in the realization of social, cultural and economic rights.

While the author fully acknowledges the limitations of the Chávez government's social policy initiatives, the paper maintains that Phase 2 provides lessons that can be transferred to other countries where there is an urgent need to rapidly address lack of access to quality health care services and unresponsive state institutions. It additionally highlights that international health knowledge and expertise can flow south to south rather than along a north-south trajectory and that effectively managed commodity dependence can realize new bilateral relationships that prioritize social need. Finally, and in line with Muntaner et al. (2008), the enormous value of Venezuela lies in demonstrating that the social determinants of health can be prioritized and addressed through innovative strategies that can provide insights for marginalized communities to increase their access to quality health services.

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